UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

15 CV 1599

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CHANDRA MCKOY, on behalf of the United States of America,

JUDGE BRODERICK

Plaintiff/Relator

-against-

ALAN E. ULISS and ALAN E. ULISS M.D., P.C.

Defendants.

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Civil Action No.

***QUI TAM* COMPLAINT AND JURY DEMAND**

(Filed *In Camera* and under Seal)

FILED U.S. DISTRICT COURT S.D. OF N.Y. 2015 MAR -4 PM 2:29

ORIGINAL

Plaintiff/Relator Chandra McKoy ("Plaintiff" or "McKoy"), by her attorneys, Beranbaum Menken, LLP, complaining of defendants Alan E. Uliss M.D., ("Uliss"), and Alan E Uliss M.D., P.C. ("PC"), (collectively, "Defendants"), alleges as follows:

PRELIMINARY STATEMENT

1. Plaintiff Chandra McKoy brings this *qui tam* action, pursuant to the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, on behalf of the United States to recover moneys wrongfully obtained by Defendants through the submission of false, fraudulent, and illegal claims for Medicare and Medicaid reimbursement. McKoy also seeks damages for Defendants' retaliation against her for her opposition to and refusal to participate in Defendants' fraudulent and unlawful conduct pursuant to the False Claims Act, 31 U.S.C. § 3730(h) and the New York Finance Law § 191. Finally, McKoy brings this action pursuant to the New York False Claims Act, State Finance Law, § 190, on behalf of the State of New York to recover money fraudulently obtained by Defendants through the submission of false, fraudulent, and illegal claims for Medicaid reimbursement, and to seek redress for her retaliatory and wrongful discharge by Defendants.

2. Defendants, for *each and every* ophthalmologic consultation, billed the taxpayer for the

highest level of service when such service was not in fact provided, and otherwise billed for services not actually provided, and structured their bills to conceal that fact by submitting diagnoses to Medicaid and Medicare for conditions the patients did not have. Defendants also routinely separately billed for services that lawfully should have been considered part of the same procedure, such as a follow-up visit after an ophthalmologic procedure. This is known as "unbundling," and is one of the quintessential Medicaid and Medicare false claims. Defendants also falsely certified that they were in compliance with Medicare's electronic health record (HER) incentive program, and so unlawfully received incentive payments under that program.

JURISDICTION AND VENUE

3. Plaintiff invokes this Court's federal question jurisdiction pursuant to 28 U.S.C. § 1331. Plaintiff also brings this claim under 31 U.S.C. § 3729. The Court has supplemental jurisdiction over McKoy's state law claims pursuant to 28 U.S.C. § 1367 and 31 U.S.C. § 3732(b).

4. Venue is appropriate in this district under 28 U.S.C. § 3732(a) because the Defendants transact business in this district and a substantial number of the acts complained of herein occurred in this district.

THE PARTIES

5. Ms. McKoy resides in Brooklyn, New York. She has worked as a medical biller for over 15 years. Over the course of her career, much of Ms. McKoy's work has involved billing for Medcaid and Medicare patients. Consequently, McKoy is familiar with Current Procedural Terminology ("CPT") coding and billing procedures required to secure reimbursements under Medicaid and Medicare. CPT is a medical code set maintained by the American Medical Association that describe medical, surgical, and diagnostic services and procedures offered by

medical providers.

6. Ms. McKoy began work for Defendants on September 30, 2013. She was fired by Uliss on November 18, 2014.

7. Ms. McKoy is an "original source" of the information giving rise to the herein causes of action pursuant to 31 U.S.C.A. § 3730(e)(4)(A).

8. Defendant Alan E. Uliss is a board-certified ophthalmologist. His practice is incorporated as Alan E. Uliss, M.D., PC.

9. Uliss's National Provider Identifier number ("NPI") is 1740510304.

10. At the time of McKoy's employment, Uliss practiced ophthalmology at 110-11 72nd Avenue, Forest Hills, NY 11375. Approximately 80% of his patients were covered by Medicaid or Medicare.

Medicare and Medicaid Billing Regulations

11. Medicare, established by Title XVIII of the Social Security Act, is a federally-funded health insurance program primarily benefitting the elderly and disabled. Medicare Part B, the Voluntary Supplemental Insurance Plan, covers the cost of physician services, diagnostic tests, and other medical services not involving inpatient and nursing home care.

12. 42 U.S.C.A. § 1395y(a)(1)(A) provides that "Notwithstanding any other provision of this subchapter, no payment may be made under [Medicare] part A or part B of this subchapter for any expenses incurred for items or services…which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

13. 42 U.S.C. § 1320c-5(a)(1) requires that services billed to Medicare be "provided

economically."

14. Medicaid, established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, is a program in which the federal government distributes money to the states, which, in turn, provides medical services to the poor.

15. To obtain Medicaid funding, a state must have a plan for medical assistance. 42 U.S.C. § 1396. The plan must contain procedures relating to payment for services sufficient "to assure that payments are consistent with quality of care." 42 U.S.C. § 1396a(a)(30)(A).

16. Each state participating in the Medicaid program must have a fraud detection program, and the state plan must provide for exclusion of persons who have committed fraud or abuse. "*Abuse* means provider practices that are inconsistent with sound … medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services … that fail to meet professionally recognized standards for health care." 42 C.F.R. § 455.2 (emphasis in original).

17. Medicaid regulations also provide that the plan require that each service eligible for reimbursement "be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b).

18. 42 C.F.R. § 410.26 sets forth basic conditions for Medicare and Medicaid reimbursement for medical services incident to a physician's professional services. Section 410.26(b)(2) states that "services and supplies must be an integral, though incidental part of the services of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness." Section 410.26(b)(4) states that in order to be reimbursed, "services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner)."

19. Defendants knowingly and regularly violated Medicare's and Medicaid's legal requirements by submitting bills for reimbursement for services that were never in fact performed or that exaggerated the extent of the services provided or by providing services that were not medically necessary. Defendants also unlawfully "unbundled" services that are required to be billed together, and falsely attested that they were in compliance with the requirements of the Medicare electronic health record (HER) incentive program.

FACTS

20. Dr. Uliss' practice focuses on elderly patients, the vast majority of whom are Medicare or Medicaid beneficiaries. Dr. Uliss saw approximately 40 patients each day, about 80% of which were Medicaid or Medicare beneficiaries.

21. Defendants had one other doctor, Dr. Steven Leff, working for them part-time. All patients seen by Dr. Leff were billed under Dr. Uliss' name and NPI.

22. Plaintiff was hired by Uliss as a billing assistant, and as such she was responsible for initially generating the Health Care Financing Administration (HCFA) form for each patient, incorporating Dr. Uliss' changes, and with Dr. Uliss' approval, submitting the forms for reimbursement. Dr. Uliss instructed Ms. McKoy on numerous occasions on how he wanted his HCFA's filled out. As such, Ms. McKoy became fully familiar with Dr. Uliss' billing practices, including the unlawful practices referenced herein.

23. From the beginning of her employment, it was apparent that Dr. Uliss' office procedures were designed to maximize the amount could bill for each patient, while falsifying billing and patient records in order to avoid scrutiny.

24. For each patient appointment, Dr. Uliss used a chart note form to list medical observations and findings, as well as the level of services allegedly provided during each patient appointment. He also used a standard billing form, commonly known as a super bill, on which CPT codes are listed. Dr. Uliss used the billing form to mark the CPT codes that the practice submitted to Medicare and Medicaid for reimbursement. Plaintiff would input the information from the billing form into billing software that generates a claim form known as a HCFA form, for reimbursement from Medicare and Medicaid.

25. Dr. Uliss would frequently make changes to the HCFA form, and then certify that the information contained on the form was true and accurate, and then Plaintiff, pursuant to Dr. Uliss's direction and under his supervision, would submit the form to the relevant government healthcare benefit program for reimbursement.

Defendants' Upcoding

26. Dr. Uliss frequently upcoded, selecting CPT codes that reflected more complicated or involved care than he actually provided and that would result in larger reimbursements from Medicaid and Medicare.

27. One example of this upcoding was in the CPT codes selected to bill for a consultation with a patient. During McKoy's tenure, Uliss would always select the CPT code used for the highest level of service, 99245 for "Comprehensive Consultation," or 99215 for a "Comprehensive/Mod Revisit."

28. Medicaid and Medicare guidelines provide that this level of consultation should typically be used for a complicated case requiring a consultation of 45 minutes or more. For example, CPT 99245 requires the ophthalmologist to conduct a comprehensive and thorough consultation

including performing a physical examination, taking the patient's medical history, discussing all patient complaints and problems, reviewing all medications the patient is taking, and discussing numerous topics such as smoking, diabetes, and medication interactions.

29. A similar comprehensive physical exam and patient interaction was required to use CPT 99215 "Comprehensive /MOD Revisit." Medicaid and Medicare require that this code be used for followup visits typically taking 40 minutes or more.

30. Dr. Uliss would "upcode" all of his consultations to CPT 99245 or 99215, no matter how much time he spent with the patient. Indeed, Dr. Uliss never spent enough time with any patient or provided a level of care to justify using either one of those codes.

Medically Unnecessary and Unauthorized Procedures

31. In addition to upcoding, Defendants submitted false claims because the services provided were not medically necessary, and were in many instances administered by unqualified technicians.

32. For example, every patient would receive a glaucoma screening (CPT code 92133) and an "Optical Coherence Tomography" (OCT) test, used to test for macular degeneration, (CPT code 92134) each time they came to the office, whether those tests were medically indicated or not.

33. However, those tests are medically necessary only once per year for patients not suffering from glaucoma or macular degeneration. Dr. Uliss would have these tests performed in nearly every visit, resulting in thousands of these unnecessary tests.

34. Defendants' billing for frequent glaucoma tests is especially egregious because Dr. Uliss as a general rule did not treat patients with glaucoma. For such patients glaucoma tests are only indicated every year or two.

35. These unnecessary tests also impacted Defendants' patients directly, as they were required to pay the co-pays for those tests, which in some instances was $40 or more, in the case of some Medicaid Advantage plans recipients.

36. Dr. Uliss' claims for reimbursement for these glaucoma and macular degeneration tests were also fraudulent because those tests in most instances were administered not by him, but by unqualified technicians. To be reimburseable, both tests must be performed by a Certified Ophthalmologic Technician (COT). Four of the five technicians employed by Defendants were not COTs, although they all performed both procedures.

Unbundling

37. Dr. Uliss would also unlawfully "unbundle" services that are required to be billed under one CPT code. For example, patients returning for a followup visit after receiving retinal injections of Avastin or Lucentis (CPT codes J2778 and J9035, J3490, and J3590) would have their visit coded as a consultation (CPT 99245 or 99215) and separately billed (with a separate co-pay for the patient), even though the follow-up visit was required to be included in the bill for the procedure.

38. Indeed, for any procedure performed by Dr. Uliss, Defendants would separately bill Medicaid and Medicare for the followup visits, despite the fact that those visits were required to be included in the original bill for the procedure.

Falsification of Records

39. Each time a patient met with Dr.Uliss, he made notes on the patient's chart, and filled out a "superbill." Although the superbill is supposed to accurately reflect the patient's actual

diagnosis that required the treatment Dr. Uliss provided, Ms. McKoy observed that this was not in fact the case.

40. In fact, Dr. Uliss would falsify the diagnostic codes on the HCFA forms in order to justify his upcoding, unbundling and medically unnecessary procedures.

41. Dr. Uliss directed the Plaintiff and the other staff to provide him, at the start of the day, with a list of all the billing codes that he had previously billed for each patient, including the diagnosis code. Dr. Uliss did not need this information so he could know the patient's medical history - that would be found in the chart.

42. Rather, Dr. Uliss needed to know what diagnosis code had been used on the patient's prior visits, so that he could select a different diagnosis in order to justify upcoding the visit to the most expensive level of CPT 99245 or 99215. Dr. Uliss would also need to falsify the diagnosis in order to "unbundle" the visit from the required follow-up visits after the retinal injections were administered. The billed diagnosis would have nothing to do with the patients' actual medical condition, and would not match the diagnosis contained in the patients' chart.

43. Similarly, in order to justify his unnecessary OCT and glaucoma tests, Dr. Uliss would code a different diagnosis on the HCFA form than the diagnosis he had used on the patient's last HCFA form, in order to make it appear that the patient had a different medical condition than at the time of their last OCT or glaucoma test. This diagnosis would not be a condition that patient actually suffered from, but would be a falsehood uttered by Dr. Uliss in order to justify being reimbursed for the unnecessary testing.

44. Similarly, to conceal evidence of his "unbundling," Dr. Uliss would list a new and fraudulent diagnosis code on the later bill. That diagnosis would not reflect the patient's actual

diagnosis, but would be contrived solely to justify the separate billing for work that should have been a part of the prior billing.

45. The HCFA forms used for any care given by Dr. Leff were filled out by Dr. Uliss' staff at his direction. Thus, the same fraudulent billing was done for the patients Dr. Leff saw.

46. On occasion, some of Dr. Uliss' bills were questioned, and he was required to provide (mainly to Medicare Advantage insurers or a Medicaid HMO) additional information to justify his billing.

47. In those instances, Dr. Uliss would provide a written narrative of the care he provided based on his billing records, not his treatment notes. Thus, Defendants' response to the aforesaid audits was fraudulent, and did not reflect the care actually provided to the patient.

48. Finally, Dr. Uliss falsely certified to Medicare that he was compliant with their Electronic Health Record (EHR) incentive program, when in fact he was only using electronic health records for approximately half of his patients. Dr. Uliss did not want to use the electronic recordkeeping system because that system required the provider to input extensive information to justify the use of the 99245 and 99215 OPT codes, which Dr. Uliss could not do, because he had not provided the requisite level of care to justify billing under those codes.

49. Defendants' false certification that they were in compliance with the EHR program led to Defendants receiving an incentive payment in the approximate amount of $68,000 that they did not qualify for.

Defendants' Retaliation Against McKoy

50. As an experienced medical coder, Ms. McKoy knew that Dr. Uliss' practices were unlawful. Consequently, she would fill out the claim forms correctly, only to have Uliss change

them to confirm with his fraudulent practices. Specifically, Plaintiff would refuse to falsify the diagnosis codes according to Dr. Uliss' instructions. That forced Dr. Uliss to change the HCFA forms himself.

51. Plaintiff also frequently argued with Dr. Uliss about his false certification under the EHR program, and beseeched him to opt-out of the program rather than do so. That led to Dr. Uliss "freezing out" Ms. McKoy from any involvement in that program, and refusing to talk with her in general.

52. When Ms. McKoy was fired, Dr. Uliss told her that it was because "I'm tired of billing on Sundays." This referred to Dr. Uliss changing the HCFA forms that Ms. McKoy had filled out correctly. Thus, Ms. McKoy was fired for her opposition to Defendants' unlawful and fraudulent billing practices.

Publicity

53. Some information concerning Defendants' false claims have been reported in the media. Specifically, Dr. Uliss practice of using the 99215 CPT codes for all of his followup patient visits was reported on Channel 4 in New York City. *See* http://www.nbcnewyork.com/news /local/Medicare-Billing-Code-Expensive-Office-Visit-ProPublica-259555431.html.

54. Ms. McKoy is nonetheless an "original source" of the information concerning the false claims as recounted herein, within the meaning of 31 U.S.C. § 3730(e)(4)(B). First of all, the public information only concerns the use of the OPT 99215 code, not the six other categories of false claim Ms. McKoy has direct knowledge of, namely 1) use of the 99245 code, 2) the unnecessary glaucoma and OCT testing, 3) the performance of those tests by unqualified and unauthorized personnel, 4) Defendants' unbundling of the retinal injection follow-up visits, 5)

Defendants' falsification of records, including the use of fraudulent diagnosis codes, and 6) Defendants receipt of unearned EHR incentives.

55. In addition, Ms. McKoy is also an "original source" because the information contained herein is independent of the public information and materially adds to the publicly disclosed allegations.

56. Ms. McKoy provided the aforesaid information to the Government, pursuant to 31 U.S.C. § 3730(e)(4)(B)(I) by providing this Complaint, along with a disclosure statement with supporting exhibits, to the United States Attorney for the Southern District of New York on January 9, 2015, prior to filing with this Court.

COUNT I - VIOLATION OF 31 U.S.C.A. § 3729(a)(1)(A)

57. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-56 as if fully set forth herein.

58. 31 U.S.C.A. §3729(a)(1)(A) of the False Claims Act prohibits any person from knowingly making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the government.

59. Defendants knowingly made and caused to be made materially false statements in the bills and certifications submitted to Medicare and Medicaid, in bills, and on reports of procedures and services offered to patients.

60. The fraudulent and false statements and certifications made by Defendants were used to present false claims to Medicare and Medicaid. Each time that Defendants presented a claim to Medicare or Medicaid based upon a fraudulent document, they violated §3729(a)(1)(A) of the False Claims Act.

61. Defendants' use of false records and statements caused the government to suffer damages and pay funds to defendants to which defendants were not entitled.

62. WHEREFORE, Plaintiff Chandra McKoy, acting on behalf of the United States of America, demands that Defendants Alan E. Uliss and Alan E. Uliss M.D., P.C. pay the United States of America the penalty of not less than $5,500 and not more than $11,000 per violation, three times the amount of damages which the United States of America has sustained because of the violation of the False Claims Act, plus litigation costs and reasonable attorney's fees, and other such relief as the Court deems appropriate.

COUNT II – VIOLATION OF 31 U.S.C.A. § 3730(h)

63. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-62 as if fully set forth herein.

64. Pursuant to the False Claims Act, 31 U.S.C. § 3730(h), Defendants may not take retaliatory actions against employees who take lawful actions in furtherance of a False Claims Act action, including making internal reports about Defendants' fraudulent billing practices.

65. Plaintiff complained to Dr. Uliss about the Defendants' submission of claims for services that had not been provided by the Defendants, and were otherwise unlawful.

66. On November 18, 2014, Defendants terminated Plaintiff's employment.

67. Plaintiff was discriminated against in the terms and conditions of her employment by Defendants because she took lawful steps in furtherance of an action under the False Claims Act.

68. The actions of Defendants damaged and will continue to damage Relator in violation of 31 U.S.C. § 3730(h), in an amount to be determined at trial.

69. WHEREFORE, Plaintiff demands that Defendants reinstate Plaintiff with the same seniority status that Plaintiff would have had but for the discrimination, pay her two times the amount of back pay, interest on the back pay, and compensation for all special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

COUNT III - VIOLATION OF N.Y. STATE FINANCE LAW §190

70. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-69 as if fully set forth herein.

71. McKoy is an "original source" of the information giving rise to the herein causes of action pursuant to State Finance Law § 188(5)

72. The New York State Department of Health ("State of New York"), is the state agency administering New York's Medicaid program.

73. On information and belief, the State of New York, along with local governments, pays 50% of the costs of the claims made by providers for services rendered to individuals eligible for Medicaid.

74. The State of New York requires of Medicaid providers, among other things, that they submit claims for payment only for services actually furnished, which were medically necessary, were provided by the provider under his supervision, and which were furnished by an individual with a valid license, registration and/or certification. 18 NYCRR §§ 504.1; 504.3; 504.6.

75. Between at least 2012 (and, upon information and belief, well before that time) to the present, Defendants made and caused to be made material misrepresentations to the State of New York, and submitted and caused to be submitted false claims for payment to the State of New York or a local government in violation of the State Finance Law § 189.

76. Defendants knowingly submitted and caused to be submitted bills to the State of New York or a local government for Medicaid reimbursement of procedures and services that were never in fact rendered or that exaggerated the extent of the services provided, and resulted in unnecessary cost to the Medicaid program, in violation of federal, state, and local Medicaid regulations.

77. Defendants knew that the bills submitted by them to the State of New York or a local government, and the claims it made on the State of New York or a local government for reimbursement, were false and fraudulent because Defendants had actual knowledge that the applications and requests for payment were false.

78. Defendants conspired to defraud the State of New York or a local government by getting a false or fraudulent claim allowed or paid.

79. Defendants' submission of false claims caused the State of New York or local government to suffer damages and pay funds to Defendants which they were not entitled.

80. WHEREFORE, Plaintiff, acting on behalf of the State of New York, demands that Defendants pay the United States of America the penalty of not less than $6,000 and not more than $12,000 per violation, three times the amount of damages which the State of New York sustained because of the violation of the New York False Claims Act, plus litigation costs and reasonable attorneys' fees, and other such relief as the court deems appropriate.

COUNT IV - VIOLATION OF N.Y. FALSE CLAIMS ACT, STATE FINANCE LAW §191

81. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-80 as if fully set forth herein.

82. Defendants discriminated against McKoy in the terms and conditions of her employment by discharging her for performing lawful acts on behalf of Defendants, namely by submitting paperwork that would result in billings to Medicaid and Medicare that accurately reflected those services provided to patients by Defendants.

WHEREFORE, Plaintiff Chandra McKoy demands that Defendants be enjoined from any further violations of the statute, reinstate her, if practical, to the position she would have had but for the discrimination, reinstate all fringe benefits and seniority rights, pay two times back pay, plus interest, compensate her for special damages sustained as a result of the illegal conduct, including litigation costs and reasonable attorney's fees, and other such relief as the Court deems appropriate.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, plaintiff demands a trial by jury on all issues.

Dated: New York, New York
March 3, 2015

Respectfully submitted,

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